ILEOCÆCAL INTUSSUSCEPTION DUE TO MYOADENOMA OF THE ILEUM.

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A SCHOOLGIRL, aged sixteen years, who had always enjoyed good health, was seized January 12, 1907, with severe "cramps." The first paroxysms quickly passed away, and she was able to be about although the pains recurred at frequent intervals during the following four days. The pains were more or less general over the whole abdomen. Her bowels had moved regularly. It was not possible to ascertain the character of the stools. The patient did not vomit, nor did she feel nauseated at any time during these four days or complain of having suffered in any other way excepting from "cramps." There had been no chill nor fever.

About 2.30 P.M., January 16, she was seized with "cramps" very much more severe than she had suffered in the last four days, and I was called to see her. She was lying on her back with her right thigh drawn up and was evidently suffering the greatest agony. Occasionally she would turn over and lie flat on her abdomen. She complained of having constant pain over her whole abdomen with acute exacerbations of a colicky character which were also not localized. Her pulse was 86, of good volume and regular. Her temperature by mouth was 96.5 degrees, and by rectum normal.

On inspection the abdominal wall just below and to the right of the umbilicus was seen to protrude slightly and this protrusion or swelling transmitted the pulsation of the abdominal aorta. Palpation revealed a mass about the size of a large orange which extended just a trifle to the left of the median line and not quite to the anterior superior iliac spine. A line drawn from the umbilicus to the superior iliac spine almost bisected the mass, passing a little lower, possibly, than the centre. The swelling was painful on palpation, especially so when pressure was brought to bear over McBurney's point. There was

rigidity of the right rectus. No other portion of the abdomen was rigid or painful on pressure. Percussion showed dulness over the mass, which was completely surrounded, even below and to the right, by a resonant or tympanitic area. During the examination the patient vomited some whiskey and Jamaica ginger which had been given her by her parents. This was the only time she had vomited. Rectal examination showed the uterus and its appendages to be normal.

The patient was given an eighth of a grain of morphia and sent to the Bethesda Hospital in an ambulance. A high enema was given her, but it had no influence on the size or location of the swelling.

An operation was advised, and, assisted by Dr. Percy Shields, I made an incision through the border of the right rectus over the centre of the mass. The omentum presented itself in the incision at once and quite a quantity of clear serum escaped from the abdominal cavity. Examination quickly revealed the fact that the appendix was not the cause of the swelling, although it was bound down and surrounded by adhesions and was subsequently removed.

The mass was seen to consist of several coils of greatly distended small intestine, which was delivered out of the wound with great difficulty, being apparently bound to the posterior abdominal wall. On this account it was with great difficulty that we were able to determine the nature of the trouble. It proved, on close examination, to be an intussusception of the ileum, which could be traced through the ileocæcal valve into the colon. My finger introduced alongside of the intussusceptum showed no adhesions to be present, but a constriction was felt about an inch within, which apparently prevented a reduction of the invagination. At the suggestion of Dr. Shields this was dilated, but only after considerable effort, and the intussusceptum was gradually withdrawn from its sheath, a large quantity of clear serum escaping at the same time. The gut for a distance of 14 or 15 inches was involved and was congested to a very dark blue. The peritoneal surface was glistening and intact. Hot towels were applied until the gut became more normal. On examining the invaginated gut a pedunculated tumor could be felt within the intestinal canal. An incision was made into the gut, and the tumor, which beyond a doubt was the cause of the invagination, was removed after its

pedicle had been transfixed and ligated. It was this tumor which to a large extent rendered the reduction of the intussusception so difficult.

The tumor was about half again as large as a hazel nut. It was attached to the intestinal wall by a pedicle, which for the size of the tumor was comparatively broad. Microscopical examination of the tumor showed it to be a myoadenoma. The adenomatous portion is of the tubular variety and shows in places a slight tendency to cyst formation. The interstitial portion is largely made up of involuntary muscle. Covering the surface of the tumor we find ordinary intestinal villi. The seat of the tumor was in the mucosa.

According to the literature at my disposal, myoadenomas are of rare occurrence and are usually found in the duodenum; in this case it was located in the ileum. This tumor is not to be confounded with multiple polypoid tumors, which are papillomas and are of much commoner occurrence.

The patient made an uninterrupted and uneventful recovery. The skin sutures were removed on the tenth day, the wound having healed by primary union.